GENERAL DENTIST
SUSANNAH SHOOK, D.M.D.
AMY MORGAN, D.M.D.

PEDIATRIC DENTAL GROUP

PEDIATRIC DENTISTS
DREW MIDDLETON, D.M.D.
CHARLES BELKNAP, D.M.D.
SCOTT TOMLINSON, D.M.D.
MYEASHA BURGESS, D.D.S.
JONATHAN NICHOLS, D.M.D.

THE FOLLOWING INFORMATION AND HISTORY ARE NECESSARY FOR ADEQUATE TREATMENT AND UNDERSTANDING OF YOUR CHILD. THANK YOU FOR COMPLETING IT IN FULL.

Patient's Name ______ Nickname ______ Age ____
Sex ____ Race ____ Date of Birth ______ Place of Birth ______
Patient's Address ______ Home Phone ______
Street City State Zip
Father's Name ______ DOB ______ Social Security # ______
His Address ______ Phone ______
Street City State Zip
Where Employed ______ Phone ______
Mother's Name ______ DOB ______ Social Security # ______
Her Address ______ Phone ______
Street City State Zip
Where Employed ______ Phone ______
With whom does patient live ______
Other children in family who have received dental care in this office ______
Dental Insurance? Yes ____ No ____ Company ______ Number ______
Child's Physician ______ Family Dentist ______
Whom may we thank for referring you to our office ______
(Name)

E-mail Address ______

Doctor ☐ Dentist ☐ Patient ☐ Parent ☐ School/Day Care Visit ☐

HEALTH HISTORY

	Yes	No
Is your child in good health?	____	____
Does your child have regular medical examinations?	____	____
Is your child up to date with immunizations?	____	____
Is this your child's 1st dental visit?	____	____

Is your child a thumb/finger sucker? ____ Use a pacifier? ____
If your child was bottle fed, at what age was it discontinued? ____

Check any of the following that may pertain to your child:

____ Rheumatic fever	____ Bleeding disorder	____ Lung problem	____ Mental disorder	____ HIV/AIDS
____ Heart condition	____ Cerebral palsy	____ Brain injury	____ Emotional disorder	
____ Speech disorder	____ Liver	____ Epilepsy	____ Tuberculosis	
____ Hearing disorder	____ Kidney	____ Hepatitis	____ Sickle Cell Anemia	
____ Vision disorder	____ Asthma	____ Diabetes	____ Autism	
____ Nervous disorder	____ Allergies	____ Retardation	____ Other	

Is your child presently taking any medicine? ______ (Name of Medication) ____ ____

Has your child experienced any unfavorable reaction to medicine?
(Such as penicillin, aspirin, xylocaine) ____ ____
Is your child allergic to any drug or food? ____ ____
If so, what? ______
Is your child presently undergoing medical treatment? ____ ____
Has your child ever been hospitalized since birth? ____ ____
If so, Date: ______ Reason ______
Has your child ever had an unfavorable experience in a dental office? ____ ____
Date of your child's last dental care ______
Does your child have a toothache? ______
Purpose of this appointment ______
Thank you for your help. If there is any information that you think might be of value to us in treating your child, please feel free to comment ______

Parent bringing patient to our office is responsible to us for payment on account.

PERMISSION:

Since ______ is a minor, it becomes necessary that signed permission be obtained from the parent or guardian before any and/or all necessary dental service can be performed by Pediatric Dental Group. Authorization is hereby granted as such. Furthermore, I will be responsible financially for any bill incurred for this patient for dental treatment.

Date ______ Relationship ______ SIGNED ______

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FINANCIAL POLICY

Welcome to our practice. It is our policy to make definite financial arrangements with you before any treatment starts. Below is an explanation of our payment procedures.

1. Patient portion of services is due at the time services are rendered.
2. For new patient emergency visits, we require payment in full at the time of payment.
3. We will provide you with a copy of the charges to submit to your insurance carrier for your reimbursement or you may assign the payment to our office and we will file insurance for you.
4. Our office will file your insurance a maximum of two times per appointment.
5. If the claim is not paid by your insurance carrier within sixty days, you will be responsible for the full balance and further insurance appeal becomes your responsibility.
6. You must provide the office with a dental insurance card with the proper mailing address of the insurance company. If this is not available at the time of appointment, you will be responsible for payment of all fees.
7. If insurance benefits are assigned to the doctor, you will be responsible for paying your deductible and co-payments at the time of service. You are responsible for paying all charges not covered by your insurance company, including all fees considered above your insurance company's usual and customary fee schedule. The amount of coverage you will receive will depend on the quality of the plan purchased by your employer, not the fees of the doctor.
8. After 90 days, we will inform you of the delinquent amount by letter and if no action is taken to clear the account, this office will be required to employ a collection service to collect payment. The responsible party agrees to pay all reasonable, related collection fees.
9. For State assistant coverage (Medicaid, CHIP) and private insurance, the parent or guardian who brings the child for their initial visit is responsible for payment independent of what divorce decree or custody arrangements may state. Reimbursement must be made between the divorced parents, Pediatric Dental Group will not intervene.
10. If private insurance is filed for any remaining patient balance, it is the responsibility of the guarantor (insurance holder) on the account.

"I have read and accept the above Financial Policy and agree to the terms set forth."

Signature of Responsible Party: ______________________________ Date: __ / __ / __

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

"I have received a copy of the Pediatric Dental Group's Notice of Privacy Practices."

Patient's Full Name: ______________________________

Printed Name: ___________________________________

Relationship to Patient: __________________________

Signature: ______________________________________

Date: ___ / ___ / _____

FOR OFFICE USE ONLY:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained due to:

☐ *Refusal to Sign*

☐ *Communication Barriers Prohibited Obtaining the Acknowledgement*

☐ *An Emergency Situation Prevented us from Obtaining Acknowledgement*

☐ *Other:* ____

Patient Name: ______________________ Date: __ / __ / ____

General Dentist
Susannah Shook, D.M.D.
Amy Morgan, D.M.D.

Pediatric Dental Group

Pediatric Dentists
Drew Middleton, D.M.D.
Charles Belknap, D.M.D.
Scott Tomlinson, D.M.D.
Myeasha Burgess, D.D.S.
Jonathan Nichols, D.M.D.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any times. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person

responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing). Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services